and apparently cicatricial margin. Reposition of the guts was easily obtained on assuming the supine posture, but it was impossible to retain them in the abdominal cavity. Under antiseptic precautions the ring was exposed and its lips were drawn together by stout silver wire sutures, passed about three-fourths of an inch from the edges and a little less than half an inch part. No shock followed the operation, the patient making an excellent recovery and finding it necessary to wear a supporting bandage only a few months after the operation. He based his operation upon the fact that a firm cicatricial band of fibrous tissue is formed around foreign bodies lodged in the tissues of the body, and, although so far as he was aware, he was without precedent or authority in the operation, he had assumed that if he placed silver wires in the tissues in this manner, the fibrous tissue which would enclose them would be sufficient to close the hernial ring.—*American Surgical Association*, 1887.

EXTREMITIES.

I. **The Treatment of Ruptured and Divided Tendons.** By C. H. WILKIN, M. D. (New York). This paper presents a table of 32 hitherto unpublished cases, of which 28 were treated by suture, with good results in 22 and benefit in all. He considers the injury in two classes, simple and compound. While in the former almost all authorities seem to agree that rest and position are sufficient, yet it would seem that a better result and certainly closer apposition could be obtained by the use of the suture; of the propriety of the suture in the compound variety, there can be no question. The plan of treatment recommended, is first thorough cleansing of the part and irrigation of the sheath of the tendon with a 1–1,000 bichloride solution—except when the knee-joint is involved, when it should be 1–5,000—by means of a small English catheter with a syringe attached, cocaine anæsthesia, and the use of silk-worm gut suture, two sutures being necessary in the average tendon, one being carried transversely through the tendon and the other antero-posteriorly.—*N. Y. Med. Rec.*, April 2, 1887.

II. **Suture of the Divided Ends of a Ruptured Quadricips Extensor Tendon with Perfect Recovery.** By CHARLES

McBURNEY, M. D. (New York). A man had slipped while lifting a heavy packing box from a truck; the edge of the box struck him just above the patella, causing a rupture of the quadriceps tendon near its insertion, but no external wound. A transverse incision across the joint above the patella showed that the capsule was extensively lacerated on either side of the bone, while there was a quantity of coagulated blood within the joint cavity. The fibrous fringes and the torn ends of the muscle were turned inward. The latter were excised, the rent in the capsule was closed with catgut and the ends of the tendon were kept in close apposition by quill sutures which were secured by doubled silver wire passed through the edge of the patella. A plaster dressing was applied and the wound healed quickly, the recovery of motion being slow, but eventually complete, although the patient had refused the use of passive motion, so that there was apparently no difference between the two limbs.—*N. Y. Surgical Society*, April 13.

JAMES E. PILCHER (U. S. A.)

III. Synovial Cysts in Connection with the Knee-Joint; Synovial Cyst of the Wrist; Operations; Recovery. Mr. CHAUNCY PUZEY. Case I. Synovial cyst in calf of leg, communicating with knee-joint; synovial cyst of wrist. Patient, aged 26, had rheumatic fever four years before, when wrist joint and knee joint were most affected. A month before admission a slight contusion of wrist caused a swelling of the wrist, which had never quite recovered after the rheumatic fever. This swelling was situated over the radial side of the back of the wrist, extending from the base of the first metatarsal bone to two inches above the wrist. No heat or redness. Swelling divided into two by annular ligament. Fluctuation existed between these two portions, and a sort of crepitus could be felt within the sac on pressure. The right knee joint was considerably distended with fluid, and there was a large fluid swelling at the upper part of the calf, obviously communicating with the knee joint. Under Listerian precautions the swelling over the wrist was laid freely open by two incisions above and below the annular ligament, a few melon-seed bodies squeezed out and the sac stitched to the skin. The wound healed by granulations and the power of the wrist was afterwards greatly im-